Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: METHODIST AS-CBO 9150 HUEBNER ROAD SUITE 100 SAN ANTONIO TX 78240	MFDR Tracking #: M4-06-7058-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: ACE AMERICAN INSURANCE CO Box #: 15	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Rationale for Increased Reimbursement: "Met filing requirements."

Amount in Dispute: $4,666.00

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "Timely filing."

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Denial Code(s)	Amount in Dispute	Amount Due
11/17/2005	ASC Services for CPT code 29881	29	**$4,666.00**	$1291.49
			Total Due:	$1291.49

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Texas Labor Code §408.027, titled *PAYMENT OF HEALTH CARE PROVIDER*, effective September 1, 2005, sets out deadline for timely submitting the medical bills to the insurance carrier.
2. Division rule at 28 TAC § 102.4(h), titled *General Rules for Non-Commission Communication*, effective May 1, 2005, sets out rules to determine when written documentation was sent.
3. Division rule at 28 TAC §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective September 1, 2004 sets out reimbursement guidelines for Ambulatory Surgical Care services (ASCs).
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 4/17/2006
   - 29 –The time limit for filing has expired.

   Explanation of benefits dated 6/1/2006
   - 29 –The time limit for filing has expired.

Issues

1. Did the requestor submit documentation to support the disputed bills were submitted timely in accordance with Texas Labor Code, Section §408.027(a) and Division rule at 28 TAC §102.4(h)?
2. Is the requestor entitled to additional reimbursement in accordance with Division rule at 28 TAC §134.402?

Findings

1. Texas Labor Code §408.027(a), states "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

   Division rule at 28 TAC § 102.4(h), titled *General Rules for Non-Commission Communication*, effective May 1, 2005 states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on:
   (1) the date received, if sent by fax, personal delivery or electronic transmission or,
   (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."

   The Division finds that the requestor submitted a copy of a facsimile transmittal report that indicates that the insurance carrier received the claim for payment on February 16, 2006. This date is within the 95 day deadline for timely filing a medical bill required in Texas Labor Code §408.027(a); therefore, the requestor has supported the position that the disputed medical bill was timely filed.

2. Division rule at 28 TAC §134.402(b) states "For coding, billing, reporting, and reimbursement of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section."

   Division rule at 28 TAC §134.402(c) states "To determine the maximum allowable reimbursement (MAR) for a particular service, system participants shall apply the Medicare payment policies for these services and the Medicare ASC reimbursement amount multiplied by 213.3%."

   CPT Code 29881-Ankle arthroscopy/surgery is listed in ASC payment group 4.

   Based upon the submitted medical bill the requestor is located in San Antonio, TX in Bexar County. Bexar County is located in the reasonable charge locality 7.

   The Medicare ASC rate for ASC payment group 4 in locality 7 is $605.48.

   To determine the MAR the Medicare ASC reimbursement of $605.48 is multiplied by 213.3% = $1,291.49.

   The Division finds that the requestor is due $1,291.49 for ASC services for CPT code 29881.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports the medical bill was submitted timely to the respondent in accordance with Texas Labor Code §408.027(a). The Division concludes that the MAR for the disputed service is $1,291.49 per Division rule at 28 TAC §134.402(c). For the reasons stated above, the division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $1,291.49.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to $1,291.49 reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of $1,291.49 plus applicable accrued interest per Division rule at 28 Tex. Admin. Code §134.803, due within 30 days of receipt of this Order.

Authorized Signature	Medical Fee Dispute Resolution Officer	**11/23/2010**
		Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.